Presentation for the Subcommittee on Mental Health Of the Joint Legislative Oversight Committee on Health and Human Services

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Impact of Reform and Policy Changes on LMEs

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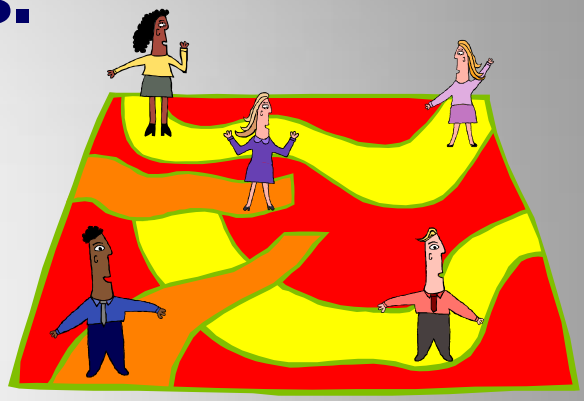
1963….

- **1963….the beginning of the Community Mental Health System in the United States.**
- **Community Mental Health Centers were established, and the *Deinstitutionalization movement began.**

***Deinstitutionalization: moving people from large institutions to the community**

For nearly 30 years, the community system grew and evolved, unplanned, according to directions set by various funding initiatives.



The system followed the funding … and there was not a system level plan to guide funding policy.

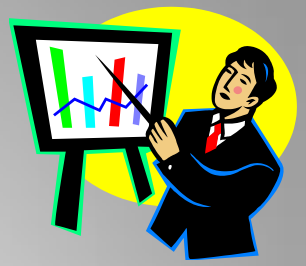
The beginning of Area Programs

- Area Programs were established in the 1970's to provide community mental health services. Some were single counties, but most were small groups of counties.
- Responsibility for community services was that of the counties, and the Area Program's role was similar to that of county based DSS and Health Departments.
- At this time, county funding was a significant component of the mental health service budget just as it continues to be for the county based DSS and Health Departments.

State Funding

- State funding was the major source of funding for community programs in the 1970s and 1980s. The foundation of the community system was built on stated funded models.
- However state funding has not been a source for system expansion and development for 20 years. Only a few special initiatives (crisis services and inpatient capacity in community hospitals) have been funded.
- State funding has not been adjusted for inflation or population growth since the early 1990s.

The Beginning of Medicaid



- **North Carolina began to access Medicaid funding for community services in the late 1980s.**

- **Medicaid funded services rapidly expanded throughout the 1990's.**

Community Service Providers

- **Prior to the 1990s, North Carolina providers were mostly local non-profits providing primarily DD and Substance Abuse services.**
- **There were very few providers of mental health services. Most mental health services were provided by the Area Programs according to the initial mission established in the 1970s.**

Rapid Expansion .....

- During the 1990's national specialty service providers arrived in North Carolina, initially to develop ICF-MR group homes, but by 2004 had expanded into a wide variety of Medicaid services as well as specialized services to meet the needs of *Thomas S class members.

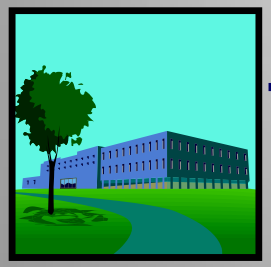
*Thomas S. Lawsuit: Class Action on behalf of adults with mental retardation that were inappropriately served in the state's psychiatric hospitals.

- New North Carolina based providers were established that were largely focused on the expansion of child mental health services which resulted from the **Willie M. class action lawsuit.

** Willie M. Lawsuit: 1979-1999 ; Class Action on behalf of adolescents that were in general mentally ill with violent behaviors that were not receiving appropriate treatment.

During the 1990s, there was concern that Medicaid funds would be block granted to the states. North Carolina had only recently taken advantage of Medicaid for community services. So, there were efforts to "catch up" before Medicaid was capped.

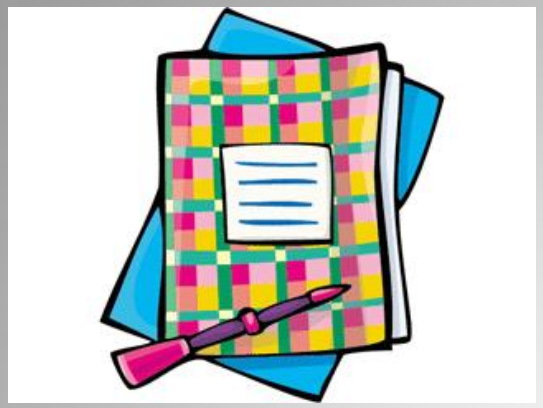
As a result of all these factors and more, community services that began in the 1970s, and expanded through the 80s and 90s, were unevenly distributed, resulting in lack of a statewide community system and inconsistent access for NC citizens.



This meant that significant numbers of people continued to be served in the state psychiatric and developmental centers. As a result, North Carolina continued to be overly reliant on institutional care.

Many of these initiatives resulted in the development of community capacity for people with complex disabilities that had previously been served in institutional settings such as the state facilities and juvenile detention centers.

The expansion of the community system through Medicaid funded services and program development resulted in services for many people who had not been served previously.



2000: The PCG Study

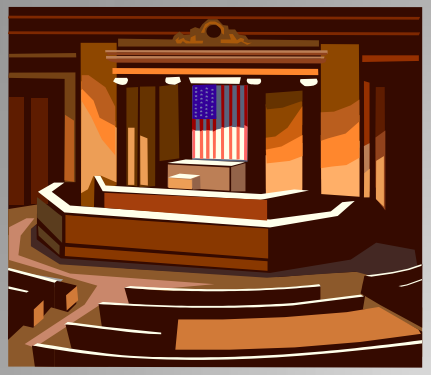
The PCG study published in 2000 noted the following:

- **The concentration of state resources in state operated facilities.**
- **Too much money spent on too few people, mostly directed to large congregate facilities, including state hospitals, and small groups of individuals that NC was under court order to serve.**
- **The absence of a consistent system of services at the community level.**

The PCG study concluded that a clear and coordinated funding policy should be developed to accomplish the major changes needed in the North Carolina system.

North Carolina's funding policy has been shaped by a number of plans, policies and departments:

- **State Medical Facilities Plan** for psychiatric inpatient beds and Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Developed by the State Health Coordinating Council.
- The **Medicaid Waiver for people with Developmental Disabilities** that were at risk for institutional placement (CAP-MR/DD). Developed by the Division of Mental Health.
- The **Medicaid State Plan for Behavioral Health Services**. Developed by the Division of Medical Assistance in consultation with the Division of Mental Health.
- Programs to address the **Willie M** and **Thomas S.** lawsuits. Developed to meet court requirements.
- **Specific programs and services** funded by state and federal dollars. Developed by the Division of Mental Health and federal agencies such as SAMHSA.



The System Reform Legislation of 2001:

- Acknowledged resources as limited, therefore the need to direct these to those greatest in need.
- Addressed the uneven distribution of community services and the need for a core set of services that would be available statewide.
- Established Consumer Family Advisory Committees.
- Changed the role of the Area Programs to Local Management Entities.

The Goals of Reform

- Separate Service Provision from Service Delivery
- Reduce State Hospital Utilization
- Consolidation of LMEs for economic efficiency
- Reinvest State Hospital savings into the community
- Develop uniform Community Service array
- Develop local Crisis Systems
- Encourage "Recovery" Services and Culture
- Reduce Out of Home Placements for children
- Consumer Empowerment and engagement
- Develop Evidence Based Best Practices
- Easy Access to Care
- Utilization and Resource Management
- Competitive Provider Networks
- Targeted benefits to defined populations

Area Program Status in 2001:

- Most Area Programs directly operated many services, but in particular, Community Mental Health Centers.
- Area Programs provided case management services.
- Area Programs contracted with providers for both State and Medicaid services.
- Area Programs were the link between providers and the state.

2002-2004

North Carolina	PBH Pilot
LMEs develop Local Business Plans as required by the 2001 Legislation, and in accordance with the Department's Blueprint for Change.	PBH completes Local Business Plan and uses it as basis for developing the Medicaid Waiver Pilot.
Some LMEs begin divestment of services that they operate.	PBH divestment completed by June 2004.
Single stream funding first implemented at PBH is implemented later for other LMEs.	2003-2004 PBH obtains single stream state funding and state hospital funds as part of pilot.

2005-2006

North Carolina	PBH Pilot
Providers begin to direct bill for Medicaid services. LMEs left with management of only state funded services.	PBH begins to operate Medicaid waivers, paying for all state and Medicaid services including state hospitals, community hospitals and ICF-MR services.
ValueOptions begins to authorize behavioral health and DD waiver services.	PBH authorizes all state and Medicaid services.
I/DD Targeted Case Management is transferred to private providers.	PBH operates administrative case management for I/DD.
New Medicaid Service Array is implemented in March 2006. The change to the service continuum is significant.	PBH adjusts waiver operations for the new service array.

2007-2008

North Carolina	PBH Pilot
Medicaid cost over-runs.	PBH achieves cost savings through Medicaid waivers.
Proliferation of providers under the Fee for Service "any willing provider" requirements. Qualifications for providers to enter the system were low.	Closed provider network according to projected utilization and quality requirements.
Newly established and poor quality providers drive up utilization, increase competition and compromise capacity of quality providers to compete while maintaining quality practices.	Performance standards and provider participation in the Quality Improvement process results in high levels of service quality.
Community Support costs escalate beyond any expectation.	Community Support costs are not high and managed within waiver funding.

2007-2008: The recession hits North Carolina

- The NC unemployment rate increases from 4.8% in August 2007 to 9.7% in August 2012.
- Increased demand for services from uninsured citizens. North Carolina's rate of uninsured citizens rose by 3.1% from 2007 to 2009, the largest percentage increase in the nation for that time period.
- North Carolina's current rate of uninsured citizens is in the 20% range.
- NC Medicaid enrollment increased by 9.8% from 2001-2004, 5.5% from 2004-2007, and 17% from 2007-2009.

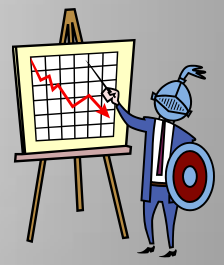
2007-2008 continued

- North Carolina and North Carolina counties face serious budget shortfalls.

- The General Assembly begins to phase out county match for Medicaid (15% of non-federal share), in exchange for transfer of sales tax. Counties continue to be responsible for the non-federal share of administrative costs for Medicaid. Phase out of county match to be completed by 2009-2010.

2008/09 - 2009/10

- Legislation is passed that expands the Medicaid waiver pilot to two other LMEs.
- Three way contracts are funded to add community inpatient hospital capacity in order to reduce use of state hospitals.
- Reduction in Medicaid rates to providers due to budget shortfalls.
- DHHS declaration of state policy to expand waiver.
- National Health Reform (the Affordable Care Act) passes, March 2010.



2009-2010

North Carolina	PBH Pilot
Legislation passed to expand waiver to two additional LMEs: Mecklenburg and Western Highlands are selected.	Legislation preventing PBH from expanding to additional counties. Mergers with Five County and OPC LMEs on hold. Waiver expansion on hold for PBH.
Three way contracts to provide for inpatient psychiatric capacity in community hospitals.	PBH has had state hospital funds since 2003, and has contracts with community hospitals for uninsured and Medicaid inpatient hospitalization.
CABHA initiative effective 7-1-10. Purpose to remedy lost community capacity for clinical and psychiatric services.	PBH did not lose community capacity for clinical and psychiatric services because of the Comprehensive Provider Model established in 2006.

New legislation establishes a long term plan for the community system

- **June 2011 HB 916: legislation sets forth a plan to expand the Medicaid 1916 b/c waiver statewide, specifies accountability and limits management to Local Management entities.**

- **HB 916 requires further consolidation of LMEs to minimum of 500,000 general population by July 2013.**

- **July 2012 SB 191: changes to 122c are enacted that enhance the LME's capability to take on managed care waivers.**

2011-2012

North Carolina

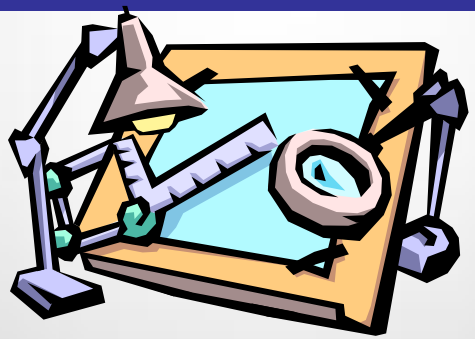
Mergers result in 11 LMEs. Mergers that occurred in 2011-2012

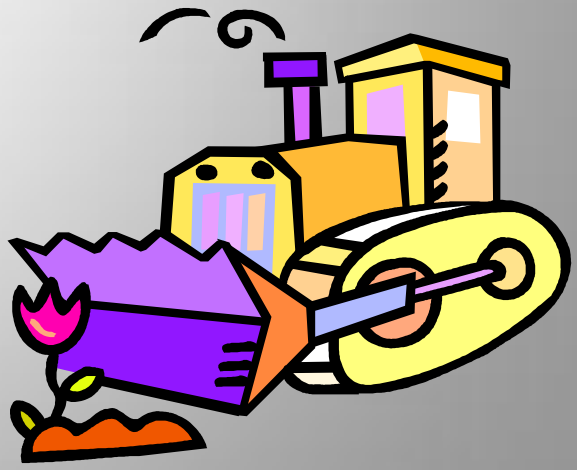
- **Alliance Behavioral Healthcare: 2 counties**
- **Cardinal Innovations (formerly PBH): 15 counties**
- **Coastal Care: 5 counties**
- **Eastpointe: 12 counties**
- **Partners Behavioral Health Management: 8 counties**

Waiver expansion to 52 additional counties for a total of 57 counties operating under the 1915 b/c waiver:

10-1-11 thru 4-1-12: PBH (10 new counties added)
1-1-2012: Western Highlands (8 counties)
4-1-2012: East Carolina Behavioral Health (19 counties)
7-1-2012: Smoky Mountain Center (15 counties)

A decade in review 2001-2012





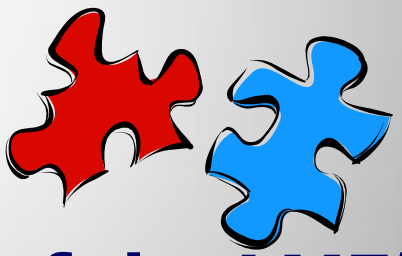
Impact of System Reform: Divestment and the Service System

- **Divestment:**
  - Divestment took place over a short period of time (2004-2006), exerting pressure for providers to expand rapidly to take advantage of the business opportunities.
  - Divestment and new Medicaid services added in 2006 resulted in system instability due to confusion about the new services, provider expansion and new providers that entered the system.
  - Divestment resulted in the loss of public community mental health infrastructure.

- **System Impact:**
  - The loss of capacity that occurred when state funded community services were divested was not anticipated. There was limited understanding of the financial models supporting these community services for the uninsured.
  - There was also a lack of provider incentives to take on the community mental health center service model because it served a large uninsured population for which there was not adequate funding, making the model untenable.
  - Licensed clinicians, psychiatrists, nurses and other professionals left the public system, resulting in a significant loss of clinical capacity at both the provider and the LME level.

Impact of Reform: LMEs

- From 2004-2010, LME mergers occurred, reducing the number of LMEs from 39 to 24, thus increasing administrative efficiency and reducing statewide administrative costs.



- Divestment of services:
  - Resulted in greater clarity of the LME's role as system manager, and ability to focus solely on management activities.

Impact on LMEs continued…..

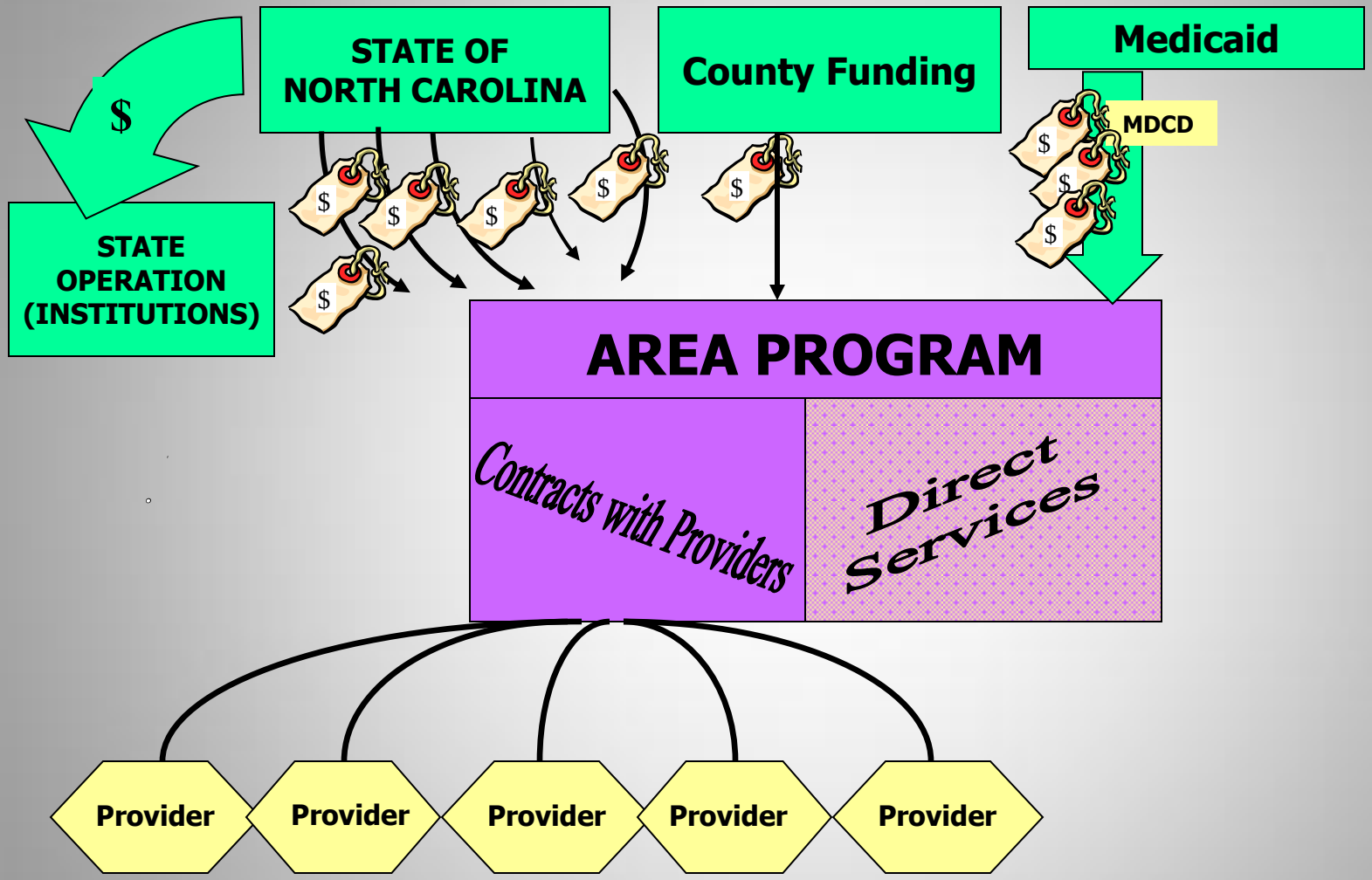
- **LMEs oversight and involvement in Medicaid at the local level was significantly diminished:**
  - **In 2005 and 2006 providers became directly enrolled in Medicaid and no longer billed through the LMEs. This resulted in ease of provider operations, but significantly excluded LMEs from Medicaid at the community level.**
  - **2006: The ValueOptions contract was renewed and expanded to authorize behavioral health and DD waiver services.**
  - **Case management moved from LMEs to private providers in 2006.**
  - **Beginning in 2009-2010, utilization review was transferred from Value Options to two, and subsequently to four LMEs.**

While LMEs continued to have a small Medicaid administrative role reviewing Person Centered Plans and conducting minor audits, they had no other Medicaid role, involvement or authority.

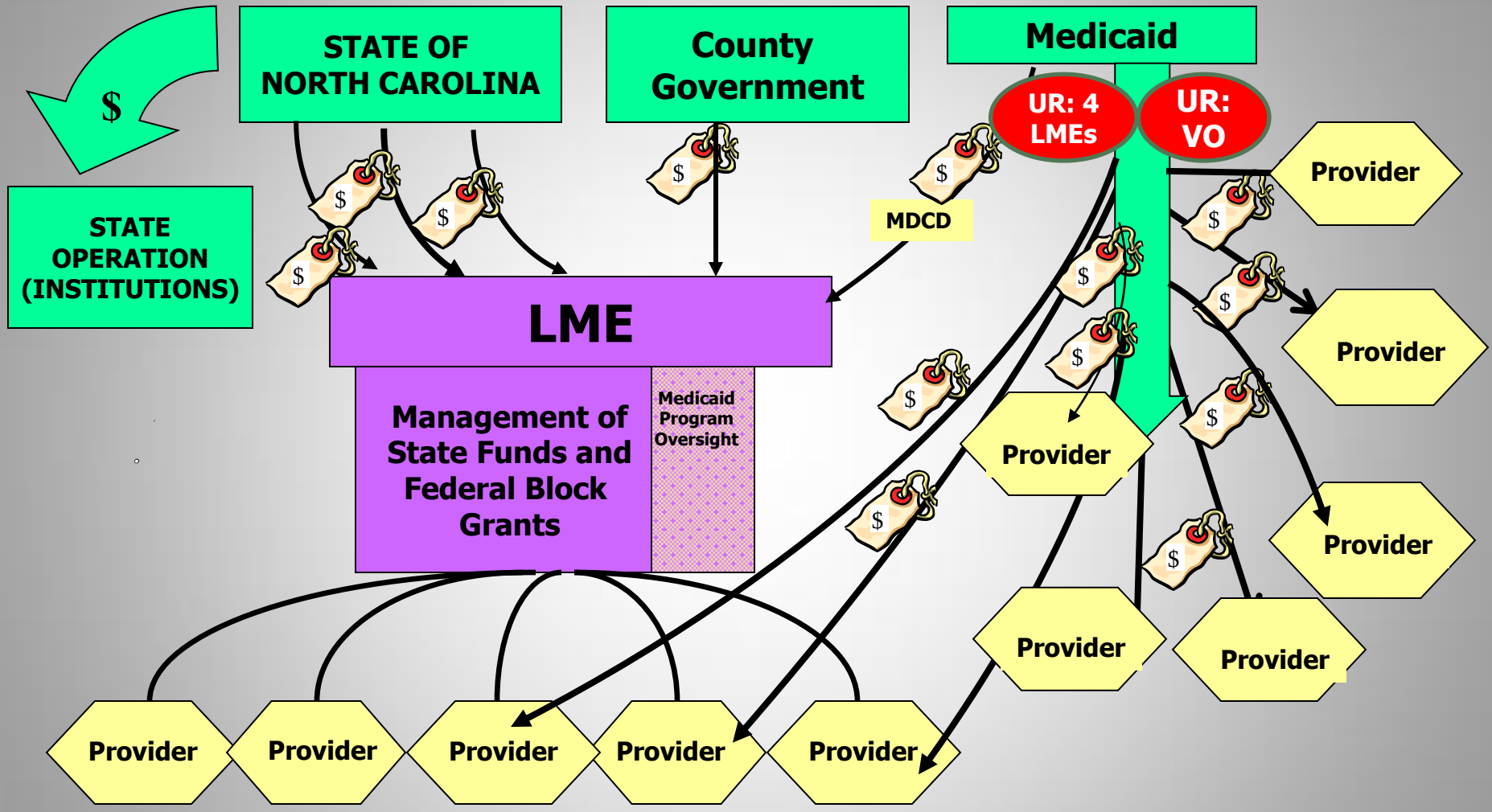
Impact on LMEs continued…..

- **Loss of administrative and clinical infrastructure:**
  - **With the divestment of services and transfer of authorizations to ValueOptions LMEs lost most or all of their staff with expertise in I/DD.**
  - **LME management of services and funding was limited to state funded services.**
  - **Fewer administrative and clinical staff were needed.**

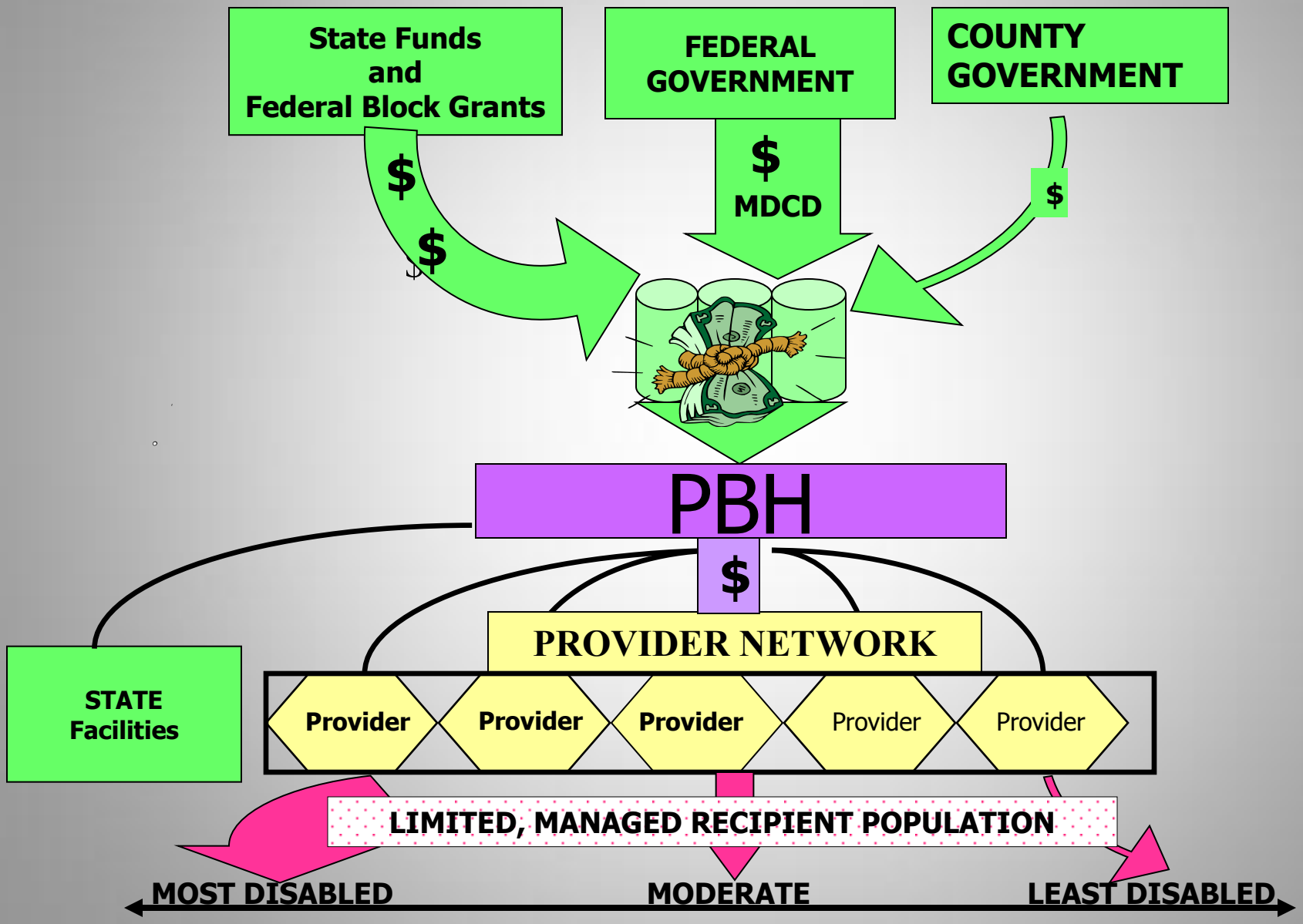
Before Reform



Current System



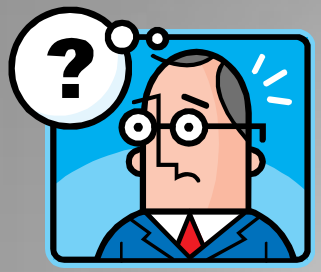
Managed Care Model



North Carolina	PBH Pilot
Unstable, uncertain environment makes providers hesitant to invest in new services, in infrastructure, and in services that require extensive management.	**Predictable business environment** for providers; providers make investment in quality infrastructure and interest in expanding services is high.
Accountability dispersed across ValueOptions, LMEs, providers of case management, DMA (for directly billed fee for service Medicaid), DMH.	**Single point of accountability** for all publicly funded services to DMA for Medicaid, and DMH for state funded services.
Escalating Medicaid costs.	**Predictable Medicaid costs.**
Cost over-runs and no savings.	**Reinvestment of Medicaid savings** into additional services.
No entity is responsible for Access to care and geographic equity; Services not distributed to sparsely populated areas; services with higher overhead may not be available	**Single responsibility for access** to care; meaning responsibility for distribution of provider services to all geographic areas is that of the LME.

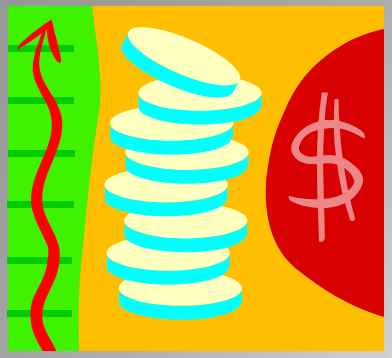
System Reform Score Card

	Goals of System Reform:
	Establish Consumer Family Advisory Committees
+/-	Develop a standard set of services that are consistently available across North Carolina.
	Create administrative efficiencies by requiring mergers among LMEs.
	Separate service management from service delivery.
	Move service provision to the private sector.
+/-	Move state funding from regional facilities to the community system to create community capacity.



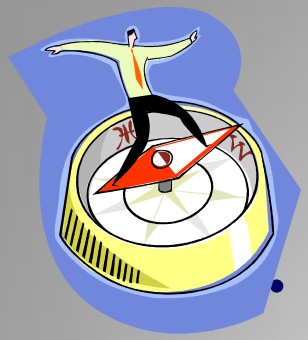
Unintended and Unexpected

- Service Silos resulted from the separation of Medicaid management from the LMEs.
- The system becomes more fragmented.
- Unmanaged system: no single entity has authority and control of how the various funding streams come together to support a system of care at the local level.
- Recession and impact on North Carolina budget.
- Escalating Medicaid costs.
- Loss of capacity to serve the uninsured due to the loss of state funds, increase in numbers of uninsured, and divestment of LME operated services.
- Too many providers.
- Loss of LME administrative infrastructure and disability specific expertise.



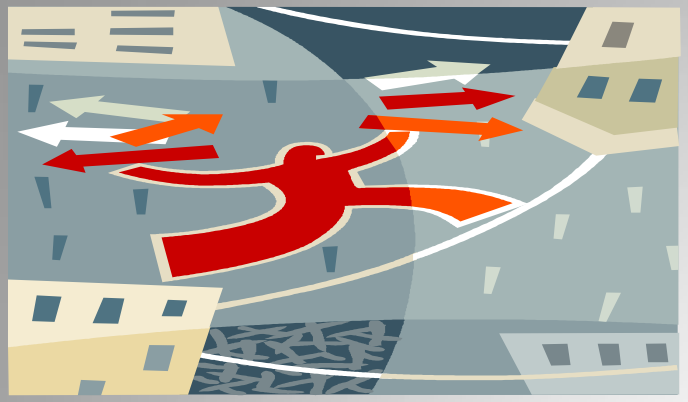
Community System Status

- **Medicaid is increasingly the dominant funding source for the community system. Medicaid policy will shape the system of the future.**
- **State budget limitations require Medicaid to be managed, as is the case in nearly all other states.**
- **The remaining 11 LMEs are rebuilding their infrastructure in order to become Medicaid MCOs.**



NC System Challenges

- **Legal challenges to Medicaid Managed Care in Federal Court.**
- **Consumer fear and uncertainty about the impact on their services.**
- **State regulatory and statutory framework is designed for state funded services or fee for service Medicaid.**
- **The State has not yet fully adapted its management activities and policy to the paradigm shift from a state funded/fee for service community system to a Medicaid Managed Care community model.**
  - **For example: in 2004, the PBH budget was 70% state funded, 2% county and 28% Medicaid. Today the PBH budget is 80% Medicaid, 18% State, and 2% county.**



External Challenges

- Rapid changes in healthcare driven by the Affordable Care Act.
- Need to integrate and coordinate care, technology, and funding across all health systems.
- Medicaid budget constraints driven by increasing enrollment and escalating costs.
- Commercialization of Medicaid and profit potential for commercial insurers.

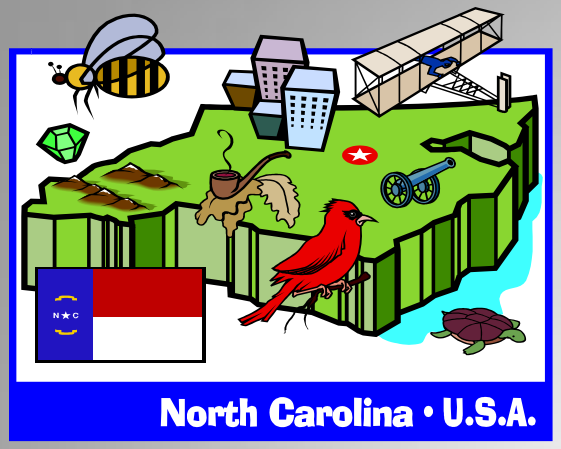
Why Continue Down this Road?

The Medicaid Budget

- The Medicaid Managed Care waivers offer NC a way to keep I/DD and Behavioral Health services intact, rather than eliminating services.
- Costs can be controlled and reduced over time in ways that do not negatively impact individual consumers.
- Regardless of the impact of national health reform, we know that the structure, financing, and management of the community system must change.

Why Managed Care ?

- accountability
- quality of care
- consumer outcomes
- stable business environment
- efficient, effective, and predictable expenditure of public funds



Managed Care—Advantages for North Carolina:

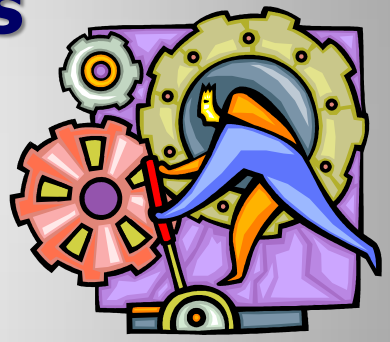
- **Sum Certain:** predictable expenses. The state knows the cost prior to the start of the fiscal year.
- **Consumer Care:** Outcomes include easy access to care, quality services and improved quality of life
- **Accountability:** single point of responsibility. Deliverables are defined through contact, and the MCO is held accountable.

Managed Care assurances include:

- Geographic access to services (within 30-45 miles).
- A provider network that has sufficient capacity to offer choice and serve all people needing care.
- Outreach by the managed care organization to ensure people receive the care they need.
- Monitoring to ensure that people are not under or over served.
- Extensive quality assurance requirements.
- Appeal rights if people served do not agree with the decision of the managed care organization.

State Options for Reducing Costs:

- In a fee for service system, states can only save money by:
  - Limiting the amount of services
  - Eliminating services
  - Reducing rates



- And these strategies can only be implemented through uniform application across populations or providers; services or systems of care.

Managed Care

Managed Care is the only proven cost management strategy that can be implemented one person at a time, and take into account the needs of individuals, while achieving cost efficiencies.

North Carolina has a good plan for the future of the community system. We have the potential to successfully implement a publicly managed, privately delivered system of care that will ensure that the citizens of North Carolina receive the care that they need in the communities where they live.

This can be achieved!